Department of Veterans Affairs
Office of Inspector General
January 2015 Highlights

OIG REPORTS

OIG Identifies Top Five VHA Shortage Occupations To Meet Veterans Access, Choice, and Accountability Act Reporting Mandate

The Office of Inspector General (OIG) conducted a determination of Veterans Health Administration (VHA) occupations with the largest staffing shortages as required by Section 301 of the Veterans Access, Choice, and Accountability Act of 2014. OIG interpreted "largest staffing shortage" to encompass broader deliberation than simply the number needed to replace or backfill vacant positions. OIG performed a rules-based analysis on VHA data to identify these occupations. OIG determined that the five occupations with the "largest staffing shortages" were Medical Officer, Nurse, Physician Assistant, Physical Therapist, and Psychologist. This determination is the first of several OIG determinations on VHA occupational staffing shortages. OIG plans to incorporate additional data in future determinations to provide more detailed recommendations. OIG recommended that the Interim Under Secretary for Health continue to develop and implement staffing models for critical need occupations. [Click here to access report.]

Veterans Referred for Outside Urologic Care by Phoenix Health Care System Potentially at Risk for Being Lost to Follow-Up

During OIG's 2014 review of scheduling practices and wait times at the Phoenix VA Health Care System (PVAHCS), OIG found that large numbers of patients who were referred for urological evaluation and/or treatment experienced significant delays in either obtaining an appointment, scheduling follow-up, and/or receiving authorizations for non-VA urology care. This prompted OIG to open an expanded review, specifically focusing on access to care within PVAHCS' Urology Department. While the OIG review is ongoing, some concerning preliminary findings requiring the Interim Under Secretary for Health's immediate attention were identified. These findings suggest that delays associated with the processing of referrals through the Office of Non-VA Care Coordination (NVCC) could potentially be putting patients at risk for being lost to follow-up. As PVAHCS continues to recruit and hire physicians and mid-level providers to staff its Urology Department, it is critical that staffing and administrative processes related to non-VA authorized care be properly administered. [Click here to access report.]

Follow-Up Audit Shows More Discipline, Accountability Needed for Effective Oversight of VA Information Technology Development Projects

In June 2009, VA launched the Project Management Accountability System (PMAS). This follow-up audit assessed whether the Office of Information and Technology (OIT) took effective actions to address recommendations OIG made to strengthen PMAS in two prior audit reports. OIT has taken steps to improve PMAS. Although steps were taken to improve PMAS, more than 5 years after its launch, OIT still has not fully infused PMAS with the discipline and accountability necessary for effective oversight of IT development projects. Two OIT offices did not adequately perform planning and

compliance reviews. The PMAS Business Office (PBO) still had Federal employee vacancies and the PMAS Dashboard lacked a complete audit trail of baseline data. Project managers continued to struggle with capturing increment costs and project teams were not reporting costs related to enhancements on the PMAS Dashboard. These conditions occurred because OIT did not provide adequate oversight to ensure that prior OIG recommendations were sufficiently addressed and that controls were operating as intended. OIT also did not adequately define enhancements in the PMAS Guide. As a result, VA's portfolio of IT development projects was potentially being managed at an unnecessarily high risk. OIG also identified approximately $6.4 million in cost savings OIT could achieve by hiring Federal employees to replace contract employees currently augmenting PBO staff. OIG recommended the Executive in Charge ensure compliance and planning reviews are performed, replace PBO contract workers with Federal employees, modify the PMAS Dashboard so that it retains a complete audit trail of baseline data, establish stronger cost reporting controls, and ensure OIT reports enhancement costs on the dashboard. The Executive in Charge concurred with all but one OIG recommendation and provided acceptable planned corrective actions. OIT did not concur with Recommendation 4, stating that contractors are needed due to increases in workload. OIG's audit evidence provides a sufficient and reasonable basis for its findings and conclusions. Thus, where OIT disagreed, OIG will continue its scrutiny and reporting and will follow up on OIT's implementation of corrective actions. The Executive in Charge also provided technical comments which were considered but not included in this report. OIG continues to retain our position that it would be more economical to perform the PMAS Business Office workload by replacing contract employees with Government employees.
[Click here to access report.]

Review Finds Need for Triage Guidelines and Training at Alamosa, Colorado, Community Based Outpatient Clinic

OIG conducted an inspection to determine the validity of allegations of poor quality care and lack of courtesy provided to a patient at the VA Eastern Colorado Health Care System's Alamosa Community Based Outpatient Clinic (CBOC). The complainant alleged that a nurse did not adequately assess and triage a patient because the patient presented late on a Friday afternoon and that the nurse treated the patient with disrespect, sarcasm, and a lack of compassion. It was also alleged that CBOC staff attempted to contact the patient through his brother instead of the emergency contact on file for the patient. OIG did not substantiate that a nurse did not adequately assess the patient; however, OIG substantiated that the nurse did not appropriately triage the patient to a higher level provider based on that assessment. A physician later determined that the patient had not been appropriately triaged and took action to advise the patient to seek additional medical care; however, managers did not address the nurse's failure to appropriately triage the patient. CBOC staff reported that they were unaware of formal policies or procedures for the triage of walk-in patients. OIG could not substantiate that the CBOC nurse was disrespectful, sarcastic, or uncompassionate to the patient. OIG could not substantiate that a CBOC staff member contacted the patient's brother instead of the emergency contact listed in the patient's electronic

health record. OIG made two recommendations to the Director of the VA Eastern Colorado Health Care System. [Click here to access report.]

Allegations Regarding Ophthalmology Service at VA Illiana Health Care System, Danville, Illinois, Not Substantiated

OIG conducted an inspection to assess the merit of allegations made by an anonymous complainant about the Ophthalmology Service at the VA Illiana Health Care System (facility), Danville, IL. OIG did not substantiate that surgery was performed on the wrong eye of a patient, or that the ophthalmologist ordered an antibiotic late. OIG did not substantiate that the patient's death was due to two eye infections or that the facility Mortality and Morbidity Committee "covered up" issues related to the patient. OIG did not substantiate that an ophthalmologist was using unsterile instruments. OIG did not substantiate that the ophthalmologist did not perform retinal exams or treat glaucoma due to an inability to read optical coherence tomography tests. OIG substantiated that the ophthalmologist saw a patient in her private practice but the patient was sent back to the VA appropriately. OIG did not substantiate that patients were referred inappropriately to private practices. OIG substantiated that patients were not referred back to the facility's Optometry Service after surgery, but this was appropriate for workflow reasons. OIG substantiated that the ophthalmologist was taking VA patient records to her private practice; however, the facility was aware, and personally identifiable information (PII) was protected. OIG noted that three investigations showed serious interpersonal problems amongst the staff and providers of the service, but recommended actions had not been taken. OIG recommended that all recommendations for interpersonal training for the staff and providers in the Ophthalmology and Optometry Services be implemented. [Click here to access report.]

OIG Review Refutes Allegations of Insufficient Staffing and Consult Management Issues at Carl Vinson VA Medical Center

OIG conducted an inspection in response to allegations of insufficient staffing and consult management issues at the Carl Vinson VA Medical Center (VAMC), Dublin, GA. OIG substantiated that telemetry technicians monitor telemetry patients without registered nurse supervision; however, we did not find this practice to be improper. OIG did not substantiate the allegation that when nursing assistants provided close observation (visual monitoring of a patient every 10–15 minutes), it increased the nursing assistant's likelihood of being injured. OIG substantiated the allegation that, at times, unit 8A East staff scheduled for the midnight tour worked shifts other than their regularly scheduled tours of duty. However, the facility's standard operating procedures for nurses state that tour changes, compensatory time, and overtime are to be used to assure adequate staffing when reassignment of staff from another area is not feasible. OIG did not substantiate the allegation that the 8A East midnight tour had a staffing mix of 1 registered nurse (RN) and 2 nursing assistants (NAs) to care for 28 patients. The usual 8A East staffing assignment for the midnight tour included one RN, one licensed practical nurse, and two NAs. OIG did not substantiate the allegation that Non-VA Care Coordination (NVCC) staff members assigned to a consult clean-up project were not properly trained to process backlogged NVCC consults. OIG made no recommendations. [Click here to access report.]

Combined Assessment Program Reviews
In January 2015, OIG published six Combined Assessment Program (CAP) reviews containing OIG findings for the facilities listed below. The purpose of the CAP reviews was to evaluate selected health care facility operations. Topics reviewed may vary due to differences in services provided at each facility, the need to follow up on previous CAP findings, or the rotation of CAP review topics over time. The reviews covered the following 12 activities: (1) quality management, (2) environment of care, (3) medication management, (4) coordination of care, (5) magnetic resonance imaging safety, (6) acute ischemic stroke care, (7) surgical complexity, (8) emergency airway management, (9) continuity of care, (10) mental health residential rehabilitation treatment program, (11) community living center resident independence and dignity, and (12) construction safety.
Gulf Coast Veterans HCS, Biloxi, Mississippi
Hampton VAMC, Hampton, Virginia
Memphis VAMC, Memphis, Tennessee
Samuel S. Stratton VAMC, Albany, New York
St. Cloud Veterans HCS, St. Cloud, Minnesota
Wilkes-Barre VAMC, Wilkes-Barre, Pennsylvania

Community Based Outpatient Clinic Reviews
In January 2015, OIG published six CBOC reviews containing OIG's findings at select CBOCs and primary care clinics that fall under the oversight of the parent facilities listed below. The purpose of the CBOC reviews was to evaluate four operational activities: (1) human immunodeficiency virus screening, (2) outpatient documentation, and (3) environment of care, and (4) alcohol use disorder.
Gulf Coast Veterans HCS, Biloxi, Mississippi
Memphis VAMC, Memphis, Tennessee
Samuel S. Stratton VAMC, Albany, New York
St. Cloud Veterans HCS, St. Cloud, Minnesota
Tomah VAMC, Tomah, Wisconsin
VA Illiana HCS, Danville, Illinois

CRIMINAL INVESTIGATIONS

Daiichi Sankyo, Inc. Agrees To Pay $39 Million To Resolve Civil Allegations
Daiichi Sankyo, Inc., a global pharmaceutical company, has agreed to pay the United States and state Medicaid programs $39 million to resolve civil allegations under the False Claims Act. A VA OIG, Federal Bureau of Investigations (FBI), Defense Criminal Investigative Service, and Health and Human Services OIG investigation revealed that the company was paying kickbacks in the form of honoraria payments, meals, and other remuneration to physicians who participated in speaker programs from January 2004 to March 2011. The VA's portion of the total damages is $547,206.

Company Reaches Civil Settlement of $44.5 Million with Federal Government
A records and data management company reached a civil settlement of $44.5 million with the Federal government for violation of the False Claims Act. The agreement

resulted from a multiple agency investigation into allegations that the company overcharged Federal agencies for record storage services under several GSA contracts. The company overcharges included mischarging for shelf space, failing to provide GSA with accurate information about the company's commercial sales practices, and failing to comply with the price reduction clause of the GSA contracts. The VA contracts were for approximately $12 million.

Long Beach, California, VAMC Pharmacist, Three Pharmacy Technicians, and a Distribution Supervisor Sentenced for Drug Theft
A Long Beach, CA, VAMC pharmacist, three pharmacy technicians, and a distribution supervisor were sentenced to 2 days' incarceration, 3 years' probation, 30 to 60 days' community service, and ordered to pay $150 in restitution after pleading guilty to computer access and fraud or receiving stolen property. An OIG investigation revealed that the defendants diverted non-controlled VA medications or knowingly received stolen VA medications. Since 2011, over 16,000 tablets of prescription medications were diverted from the pharmacy robots and an unknown amount of medication was stolen from the pharmacy shelves or from the medication parcels that were returned to the VAMC in the mail. Subsequent to the investigation, nine pharmacy employees retired, resigned, or were terminated.

Gainesville, Florida, VAMC Nurse Charged With Drug Diversion
A Gainesville, FL, VAMC RN was charged with fraudulently acquiring controlled substances. An OIG investigation revealed that on multiple occasions the defendant diverted meperidine and fentanyl from a medical unit's Pyxis machine for her own use.

Subject Arrested for Drug Possession with Intent To Distribute
A subject was arrested in Puerto Rico for possession with intent to distribute a controlled substance for his involvement in a conspiracy to distribute more than 5 kilograms of cocaine on VA property. Following the arrest, a search warrant was executed at a storage unit rented by the defendant, and approximately 1.2 kilograms of cocaine and approximately $30,000 in cash were seized. An OIG, U.S. Postal Inspection Service, VA Police Service, and Drug Enforcement Agency investigation revealed that six U.S. Postal Service Priority Mail parcels, each containing 1 to 2 kilograms of cocaine, were previously mailed by the defendant from Puerto Rico to the Bronx, NY, VAMC warehouse.

Veteran Sentenced for Drug Distribution
A veteran was sentenced to 9 to 18 months' incarceration and 2 years' probation after pleading guilty to the delivery of heroin on VA property. The defendant was identified as the seller of heroin to another veteran on VA property during an OIG, VA Police Service, and county police investigation.

Veteran Sentenced for "Doctor Shopping"
A veteran was sentenced to between 6 and 23½ months' incarceration, 10 years' probation, and ordered to undergo substance abuse and mental health evaluations after pleading guilty to obtaining a controlled substance by misrepresentation, fraud, forgery

or deception. An OIG and Pennsylvania Office of Attorney General investigation revealed that for 5 months the veteran received over 1,000 tablets of Schedule II controlled substances from both VA and non-VA sources.

Former Atlanta, Georgia, VAMC Physician's Assistant Indicted on Multiple Charges

A former Atlanta, GA, VAMC physician's assistant was indicted for conflict of interest, receipt of a gratuity by a public official, and conspiracy. An OIG investigation revealed that from July 2009 to January 2010 the defendant, while employed with VA, accepted $500 per month from a medical supply distributor to promote a wound care product to fellow medical providers. The defendant continuously placed a large amount of orders for the same product, which were paid for by the medical center. The defendant did not disclose to anyone at the VAMC that she received compensation based on the sales of the medical product. Further investigation revealed that the defendant, on her personal computer, also compiled protected health information and PII from veteran patients she treated to compare the effectiveness of wound care treatment options while using the wound care product. The defendant subsequently resigned from VA and accepted a position with the manufacturer of the wound care product.

Long Beach, California, VAMC Employee Sentenced for VA Pension Benefit Fraud

A veteran and former full-time Long Beach, CA, VAMC employee was sentenced to 12 months' home confinement, 3 years' probation, and ordered to pay $60,746 in restitution. An OIG investigation revealed that while employed by VA the defendant applied for and received VA pension benefits which are limited to low income veterans. The defendant failed to disclose that between 2007 and 2011 he had earned approximately $155,000 in wages from VA. The employee resigned in lieu of termination.

Former Seattle, Washington, VAMC Employee Pleads Guilty to VA Travel Benefit Fraud

A former Seattle, WA, VAMC employee, who is also a veteran, pled guilty to submitting false statements to the Government. An OIG investigation determined that the defendant submitted false travel benefit claims for himself and his wife while he was working as a VA travel clerk.

Former VA-Appointed Fiduciary Arrested for Theft

A former VA-appointed fiduciary was arrested for aggravated theft and criminal mistreatment. An OIG and local sheriff's office investigation revealed that the fiduciary misused the accounts of two veterans as well as numerous other non-veterans for personal gain. The loss to VA is $36,378.

Veteran Indicted for Assaulting East Orange, New Jersey, VAMC Social Worker

A veteran was indicted for assaulting an East Orange, NJ, VAMC social worker. An OIG and VA Police Service investigation revealed that the defendant verbally abused the social worker, to include making sexually explicit comments. The defendant also spit in the social worker's face and beat her with a metal cane resulting in the employee

suffering a fractured elbow. Due to the assault resulting in bodily injury, the defendant is subject to a penalty enhancement that could include up to 20 years' incarceration.

Veteran Sentenced for Assault at Wilmington, Delaware, VAMC
A veteran was sentenced to time served (7 months) and 12 months' supervised release, 4 months of which is to be in a residential re-entry center. An OIG and FBI investigation revealed that the defendant made an emergency phone call warning of a man with a gun at the Wilmington, DE, VAMC. When VA police officers responded, the veteran pointed a handgun at the officers. The gun was later identified as a BB gun. After the veteran failed to respond to repeated commands to drop his weapon, an officer fired two shots; one shot grazed the veteran's hand. During a subsequent interview, the defendant admitted that he was depressed, wanted to end his life, and was attempting to commit 'suicide by cop.'

Veteran Sentenced for Identity Fraud
A veteran was sentenced to 18 months' incarceration, 36 months' supervised release, 100 hours' community service, and ordered to pay VA $550,849 in restitution. An OIG and Bureau of Diplomatic Security Service (DSS) investigation revealed that the defendant fraudulently enlisted in the U.S. Army using his cousin's identity after being discharged and barred from re-enlistment under his true identity. The defendant admitted to using his cousin's identity in order to fraudulently re-enlist and obtain VA compensation, education, and medical benefits. The loss to VA is $1,441,470.

Veteran Pleads Guilty to VA Compensation Fraud
A veteran pled guilty to forging military discharge certificates after an OIG investigation revealed that he received VA disability compensation by using an altered DD-214 that falsely claimed he had incurred injuries stemming from his service in Vietnam and that he had received a Purple Heart as well as a Vietnam Gallantry Cross. Although the defendant was enlisted in the Navy during that era, he was never injured, never served in a combat role, and never deployed to Vietnam. The loss to VA is $101,367.

Non-Veteran Indicted for Identity Theft
A non-veteran was indicted for possession of 15 or more access devices and aggravated identity theft. An OIG and local police investigation revealed that the defendant had involvement in an extensive identity theft fraud scheme, obtained a Florida driver's license using a veteran's identity, and received medical treatment at the Miami, FL, VAMC while using the same identity. The defendant also used the veteran's identity to obtain VA medical treatment in Ohio. The loss to VA is approximately $2,000.

Ex-Husband of Personal Care Home Owner Sentenced for Theft of Government Funds
The ex-husband of a personal care home owner was sentenced to 27 months' incarceration, 3 years' supervised release, and ordered to pay $400,417 in restitution ($258,045 to VA and $142,372 to the Social Security Administration [SSA]). A VA OIG and SSA OIG investigation revealed that the defendant's ex-wife owned and operated a

personal care home where a veteran beneficiary resided. Prior to the veteran's death, the defendant opened a joint account with the veteran and arranged for the VA and SSA benefits to be deposited into the joint account. The defendant then stole VA and SSA funds that were deposited after the veteran's death in November 1997. In 2007, the defendant opened a second joint account in the deceased veteran's name in an effort to profit from the interest earned from the stolen VA and SSA funds.

Former Home Health Aide Sentenced for Theft
A former home health aide, employed by a company contracted by VA to provide home health care services to a blind veteran, was sentenced to 6 months' incarceration, 3 years' probation, and ordered to pay $7,330 to the contractor after pleading guilty to the theft of funds from the veteran's account. The contractor had previously reimbursed the veteran. During an OIG investigation, the defendant confessed that she accessed the veteran's bank account and embezzled money without the veteran's knowledge.

Veteran and Non-Veteran Co-Conspirator Arrested for VA Education Fraud
A veteran and non-veteran co-conspirator were indicted and arrested for conspiracy to defraud the Government, theft of Government funds, and mail fraud. An OIG investigation revealed the defendants fraudulently received Chapter 33 VA education benefits and also assisted other veterans in receiving VA educational benefits that they were not entitled to receive. The loss to VA is approximately $108,000.

Veteran Pleads Guilty to Theft of VA Education Benefits
A veteran pled guilty to theft of Government funds after an OIG investigation revealed that he falsely claimed to be attending school at a local community college. In fact, the defendant was overseas for much of the time that he was supposed to be attending classes. The defendant made these fraudulent claims in order to obtain Post 9/11 GI Bill benefits and carried out his scheme by obtaining and submitting VBA documentation used by schools to certify enrollment. The loss to VA is $75,955.

Richard J. Griffin
Deputy Inspector General